



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

Respondent Name

CHUBB INDEMNITY CO

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-11-2722-01

MFDR Date Received

APRIL 11, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule states that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. Although the denial explanation is understandable it does not apply in this instance. The denial code and their description are too vague for our facility to determine the basis for the denial. **This denial is not in compliance with Rule § 133.3.**"

Amount in Dispute: \$156.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor argues the denial is not valid per Rule 133.3, but that is not accurate. On date of service for December 20, 2010, the Requestor billed CPT 97032 for \$35.00. This code was denied for theat [sic] date of service with the ANSI code 107 (Denied because qualifying service not paid or identified) and R95, which is a medicare CCI Edit code because 97032 must be billed with a therapeutic procedure unless preauthorized. The use of modalities as stand alone treatment is not indicated as a sole approach to rehabilitation. See LCD # 4Y-22-AB-R8. Therefore, an overall course of rehabilitative treatment is expected to consist predominately of therapeutic procedures, with adjunctive use of modalities. 97032 should be billed in conjunction with a therapeutic procedure code. See LCD# Y-13B-R6. Since no therapeutic procedures were performed on that DOS the Requestor's argument is invalid and 97032 was not recommended for payment. With regard to the services provided on December 22, 2010, presents a separate issue. The bills were denied per Rule 133.20(e)(2) because the medical bills must be submitted in the name of the licensed health care provider that provided the health or that provided direct supervision of an unlicensed individual who provided the health care. The documentation shows the services were provided by Dr. Syed, but not submitted in his name."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2010	CPT Code 97032-Physical Therapy Service	\$35.00	\$25.32
December 22, 2010	CPT Code 99213 – Office Visit	\$106.00	\$0.00
December 22, 2010	CPT Code 99080-73-Work Status Report	\$15.00	\$0.00

Total		\$156.00	\$25.32
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FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.021, titled *Entitlement To Medical Benefits*, effective September 1, 1993, provides for medical treatment for compensable injury to injured workers.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, 33 Texas Register 626, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
4. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the rule for medical bill submission by a Health Care Provider.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 107-Denied-qualifying svc not paid or identified.
- R95-Procedure Billing Restricted/See CMS policies
- 182-Reviewed as No Charge
- 73-Work status report
- B20-Srvc partially/fully furnished by another provider

Issues

1. Is the requestor entitled to reimbursement for CPT code 97032?
2. Is the requestor entitled to reimbursement for CPT codes 99213 and 99080-73?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 97032 based upon reason codes "107 and R95." In support of the denial, the respondent states that "This code was denied for theat [sic] date of service with the ANSI code 107 (Denied because qualifying service not paid or identified) and R95, which is a medicare CCI Edit code because 97032 must be billed with a therapeutic procedure unless preauthorized. The use of modalities as stand alone treatment is not indicated as a sole approach to rehabilitation. See LCD # 4Y-22-AB-R8. Therefore, an overall course of rehabilitative treatment is expected to consist predominately of therapeutic procedures, with adjunctive use of modalities. 97032 should be billed in conjunction with a therapeutic procedure code. See LCD# Y-13B-R6. Since no therapeutic procedures were performed on that DOS the Requestor's argument is invalid and 97032 was not recommended for payment."

A review of the progress note finds "Pt has severe swelling and is unable to perform muscle exercise." Therefore, the requestor treated the claimant with electrical stimulation with ice.

Texas Labor Code §408.021 (a) states "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment."

The Division finds that the requestor's documentation supports the requestor's rationale why therapeutic exercises were not performed in conjunction with CPT code 97032. As a result, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be

effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2010 DWC conversion factor for this service is 54.32.

The Medicare Conversion Factor is 34.8729

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77004, which is located in Houston, Texas; therefore, the Medicare participating amount will be based on Houston, Texas.

The Medicare participating amount for code 97032 is \$17.19.

Using the above formula, the MAR is \$25.32; this amount is recommended for reimbursement.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT codes 99213 and 99080-73 based upon reason code "B20."

28 Texas Administrative Code §133.20(e)(2) states "A medical bill must be submitted: in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

A review of the submitted medical bill finds that in box 31 the provider is listed as "Carl C Davis Jr., MD." The work status report and office visit report indicate the provider as "Dr. Shahid Syed, M.D."

Dr. Syed is a licensed health care provider in Texas; therefore, per 28 Texas Administrative Code §133.20(e)(2) the medical must be submitted in Dr. Syed's name because he provided the service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$25.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$25.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

11/13/2013

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.